# Theme 6: Improving the Health of Our Beneficiary Population

**Summary:** CMS's programs provide health care financing for some of the Nation's most vulnerable populations. Six percent of Medicare beneficiaries account for 50 percent of Medicare spending. Two groups of beneficiaries with extensive health care needs—those over age 85 and those with end stage renal disease (ESRD)—are the two fastest growing segments of the Medicare population. As medical advances provide more effective treatments for devastating illnesses, many people will live longer, healthier lives, and will be at risk of acquiring other diseases or long-term chronic conditions. Health care purchasers and providers will be challenged to develop innovative ways to provide high-quality, cost-effective care for people with long-term chronic conditions.

## Integrated Chronic Disease Quality Performance Measurement at the Physician Level

**Project No:** 500-00-0035/01
**Project Officer:** Pauline Karikari-Martin
**Period:** September, 2001 to March, 2005
**Funding:** $452,896
**Principal Investigator:** Linda Clarke-Helms
**Award:** Task Order
**Awardee:** C.N.A. Corporation
4401 Ford Avenue
PO Box 16268
Alexandria, VA 22302-8268

**Description:** This project is to assist CMS in exploration of the issues important to physician-level quality of care scoring in chronic disease and prevention. The project will help to define quality of care for chronic disease and prevention using existing clinical performance measures and survey tools to abstract data that will be used to model these concepts. Performance measurement supports CMS program management and policy development purposes such as quality improvement in the Quality Improvement Organizations program, demonstration of accountability, and value-based purchasing. Several of our projects have attempted to integrate broader chronic disease-based thinking into their measurement structure (i.e., the Diabetes Quality Improvement Project [DQIP], the Study of Clinically Relevant Indicators of Pharmacologic Therapy [SCRIPT], and the Ambulatory Care Quality Improvement Program [ACQIP]). The primary vehicle for this initial work is applying knowledge gained using the existing clinical performance measures and survey tools at the physician office level to develop a framework for measuring quality of care in the ambulatory care setting.

**Status:** The project is under way. ■

## Healthy Aging/Smoking Cessation

**Project No:** 500-98-0281
**Project Officer:** James Coan
**Period:** October, 1998 to September, 2004
**Funding:** $200,000
**Principal Investigator:** Laurence Rubenstein
**Award:** Contract
**Awardee:** RAND Corporation
1700 Main Street
PO Box 2138
Santa Monica, CA 90407-2138

**Description:** This demonstration is testing the effect of Medicare reimbursement for smoking cessation interventions among Medicare beneficiaries who smoke in seven States. Based on an evidence report by RAND, the demonstration is evaluating the effectiveness and cost-effectiveness of reimbursement for three interventions for smoking cessation compared to "usual care." The interventions are reimbursement for provider cessation counseling alone, reimbursement for provider cessation counseling plus the use of bupropion (Zyban) or nicotine patches, and demonstration supported telephone-based cessation counseling with and without nicotine patches. Usual care includes written material only. The demonstration sites include Alabama, Florida, Ohio, Missouri, Oklahoma, Nebraska, and Wyoming.

**Status:** RAND is currently evaluating the responses from 7,354 participants to a 6-month questionnaire against baseline information collected at the time of enrollment. Responses to a 12-month questionnaire are being collected and will be compared to previously collected data. Response rates appear to be high, and a final report is expected in June 2005. ■

### Healthy Aging: Senior Risk Reduction Demonstration

**Project No:** 500-00-0034/01
**Project Officer:** Pauline Lapin
**Period:** September, 2002 to September, 2004
**Funding:** $1,993,755
**Principal Investigator:** Ron Goetzel
**Award:** Task Order
**Awardee:** Medstat Group (DC)
4301 Connecticut Avenue, NW
Suite 330
Washington, DC 20008

**Description:** The Senior Risk Reduction Demonstration (SRRD) will test whether private sector approaches to health management and risk reduction, which have been shown to be effective for reducing risk factors and health care costs, can be translated to the Medicare program. The intervention to be tested in the SRRD consists of a health risk appraisal followed by tailored ongoing interventions delivered either by mail, telephone, or Internet.

**Status:** Medstat intends to complete the design of the demonstration by January 2004. ■

### Mauli Ola (Spirit of Life) Project

**Project No:** 18-P-91142/09
**Project Officer:** Mary Kapp
**Period:** September, 2000 to September, 2005
**Funding:** $2,198,158
**Principal Investigator:** Charman Akina
**Award:** Grant
**Awardee:** Waimanalo Health Center
41-1347 Kalanianaole Highway
Waimanalo, HI 96795

**Description:** Mauli Ola ("spirit of life") is an intensive and comprehensive community-wide outreach and preventive health program. It aims to increase positive motivators at both the individual and community levels through deliberate efforts to encourage individuals, families, and the community to reassess and, where appropriate, recreate culturally relevant health and healing paradigms. Mauli Ola strategies include: (1) culturally reinforced and medically sound outreach and health awareness; (2) health screening, early detection and referral; and (3) health education, family nutrition, and exercise programs. The target population is the entire Waimanalo ahupua'a (a traditional Hawaiian integrated, self-sustaining, geographically defined community), consisting largely of Native Hawaiians and other American Asian/Pacific Islanders, located in a rural agricultural area of southeast Oahu, Hawaii.

**Status:** During the first 3 years of this 5-year project, 2,383 people have been screened for diabetes, cholesterol, and other risk factors for cardiovascular disease, including 297 who have received followup screening. Screenings have identified 126 participants newly diagnosed with diabetes, 577 with total cholesterol >200 mg/dl, 842 with blood pressure >140/90, and 1,276 with body mass index > 27. The health education program, which focuses on healthy lifestyles and includes meal preparation demonstrations, began in the summer of 2003. As of September 2003, 68 families completed the week-long program. ■

### Study on Medicare Coverage of Routine Thyroid Screening

**Project No:** 500-01-0055
**Project Officer:** Katharine Pirotte
**Period:** September, 2001 to March, 2003
**Funding:** $450,000
**Principal Investigator:** Janet Corrigan
**Award:** Contract
**Awardee:** Institute of Medicine
National Academy of Sciences
2101 Constitution Avenue, NW
Washington, DC 20418

**Description:** This is a study on the addition of coverage of routine thyroid screening using a thyroid-stimulating hormone test as a preventive benefit under Medicare. This is a mandated study (section 123 of the Benefits Improvement and Protection Act of 2000). The mandate also requires that this involves the Academy's United States Preventive Services Task Force. The study is to consider the short-term and long-term benefits, and the cost to the Medicare program of such an additional benefit.

**Status:** This study has ended and we received the final published copy of the study from IOM in spring 2003. ■

### Airway Clearance for Prevention of Chronic Obstructive Pulmonary Disease (COPD) Exacerbations

**Project No:** 18-P-91858/03-01
**Project Officer:** Carl Taylor
**Period:** September, 2003 to September, 2004
**Funding:** $99,350
**Principal Investigator:** Gregory Diette
**Award:** Grant
**Awardee:** Johns Hopkins University School of Medicine
720 Rutland Avenue
Baltimore, MD 21205

**Description:** Approximately 60 to 70 percent of patients with minor to severe COPD have chronic cough and phlegm, and recent evidence shows that chronic mucus hypersecretion is associated with greater decline in lung function, increased airway reactivity, more frequent respiratory infections and exacerbations, and increased mortality. We hypothesize that mechanical airway clearance techniques will diminish exacerbations of COPD, thereby improving respiratory health status. The specific aim of this proposal is to conduct a pilot study that is a randomized, masked clinical trial of one form of mechanical airway clearance, high frequency chest wall oscillation (HFCWO) with a pneumatic vest to determine if we can reduce the rate of COPD exacerbations. The information gained from this pilot is essential for planning a larger, national multicenter trial that will provide the definitive evidence of the efficacy of HFCWO to prevent COPD exacerbations. This study will randomly assign 50 subjects to 1 of 2 groups. The active treatment group will use a conventional vest (HFCWO) for 12 weeks, and the control group will be assigned to use a sham (deactivated) version of the vest. The primary study outcome will be reduction in COPD exacerbations. The secondary outcomes include quality of life, functional capacity, lung function, and health care use. The study will be completed in a 12-month period.

**Status:** The grant was awarded. ■

## COORDINATED CARE TO IMPROVE QUALITY OF CARE FOR CHRONICALLY ILL MEDICARE BENEFICIARIES

This demonstration tests whether coordinated care programs can improve medical treatment plans, reduce avoidable hospital admissions, and promote other desirable outcomes among beneficiaries who constitute a small proportion of the Medicare fee-for-service (FFS) population but account for a major proportion of Medicare expenditures. It is one of 15 sites selected as a part of the Medicare Coordinated Care Demonstration project to provide case management and disease management services to Medicare FFS beneficiaries with complex chronic conditions. This project will allow CMS to test a wide range of programs aimed at reducing costs and increasing quality of care for chronically ill Medicare FFS beneficiaries. The Balanced Budget Act of 1997 requires that the projects focus on chronically ill Medicare FFS beneficiaries who are eligible for both Medicare Part A and Part B and requires that the projects' payment methodology be budget neutral.

### Coordinated Care To Improve Quality of Care for Chronically Ill Medicare Beneficiaries—Arizona

**Project No:** 95-C-91318/09
**Project Officer:** Kathy Headen
**Period:** August, 2002 to June, 2006
**Funding:** $0
**Principal Investigator:** Beth Hale
**Award:** Cooperative Agreement
**Awardee:** Hospice of the Valley
3238 North 16th Street
Phoenix, AZ 85016

**Status:** Hospice of the Valley is a hospice that is offering an urban case management program to Medicare beneficiaries in Maricopa County, Arizona, with significant chronic illness. Targeting beneficiaries with various chronic conditions, the program focuses on providing and coordinating palliative care. The site began enrolling beneficiaries and providing coordinated care services in August 2002. ■

### Coordinated Care To Improve Quality of Care for Chronically Ill Medicare Beneficiaries—Baltimore, Maryland

**Project No:** 95-C-91348/03
**Project Officer:** Kathy Headen
**Period:** April, 2002 to March, 2006
**Funding:** $45,100
**Principal Investigator:** Nancy Fisher
**Award:** Cooperative Agreement
**Awardee:** Erickson Retirement Communities, Inc.
701 Maiden Choice Lane
Baltimore, MD 21228

**Status:** Erickson Retirement Communities, Incorporated, has implemented an urban case management program targeting beneficiaries with congestive heart failure, chronic obstructive pulmonary disease, coronary artery disease, hypertension, or diabetes living at Charlestown and Oak Crest Village Retirement Communities located in Baltimore County,

Maryland, and at Riderwood Village in Silver Spring, Maryland. The site began enrolling beneficiaries and providing coordinated care services in April 2002. ■

### Coordinated Care To Improve Quality of Care for Chronically Ill Medicare Beneficiaries—Florida

**Project No:** 95-C-91325/03
**Project Officer:** Kathy Headen
**Period:** September, 2002 to June, 2006
**Funding:** $63,000
**Principal Investigator:** Michael Wall
**Award:** Cooperative Agreement
**Awardee:** Quality Oncology, Inc.
1430 Spring Hill Road, Suite 106
McLean, VA 22102

**Status:** Quality Oncology, Incorporated, of McLean, Virginia, has implemented an urban disease management program focusing on beneficiaries with cancer in Broward County, Florida. The site began enrolling beneficiaries and providing coordinated care services in September 2002. ■

### Coordinated Care To Improve Quality of Care for Chronically Ill Medicare Beneficiaries—Houston, Texas

**Project No:** 95-C-91351/05
**Project Officer:** John Pilotte
**Period:** June, 2002 to May, 2006
**Funding:** $82,350
**Principal Investigator:** James O'Leary
**Award:** Cooperative Agreement
**Awardee:** CorSolutions Medical, Inc.
9500 West Bryn Mawr Avenue
Rosemont, IL 60018

**Status:** CorSolutions Medical, Inc., of Buffalo Grove, Illinois, has implemented an urban disease management program targeting beneficiaries in Texas with high-risk congestive heart failure. The site began enrolling beneficiaries and providing coordinated care services in June 2002. ■

### Coordinated Care To Improve Quality of Care for Chronically Ill Medicare Beneficiaries—Iowa

**Project No:** 95-C-91340/07
**Project Officer:** Sid Mazumdar
**Period:** April, 2002 to March, 2006
**Funding:** $50,000
**Principal Investigator:** Nancy Halford
**Award:** Cooperative Agreement
**Awardee:** Mercy Medical Center—North Iowa
1000 North Fourth Street, NW
Mason City, IA 50401

**Status:** Mercy Medical Center of Mason City, Iowa, has implemented a rural case management program targeting beneficiaries in northern Iowa with various chronic conditions. The site began enrolling beneficiaries and providing coordinated care services in April 2002. ■

### Coordinated Care To Improve Quality of Care for Chronically Ill Medicare Beneficiaries—Mahomet, Illinois

**Project No:** 95-C-91315/05
**Project Officer:** Dennis Nugent
**Period:** April, 2002 to March, 2006
**Funding:** $149,943
**Principal Investigator:** Cheryl Schraeder
**Award:** Cooperative Agreement
**Awardee:** Carle Foundation Hospital
307 East Oak, #3
PO Box 718
Mahomet, IL 61853

**Status:** The Carle Foundation Hospital of Mahomet, Illinois, has implemented a rural case management program targeting beneficiaries with various chronic conditions in eastern Illinois. The site began enrolling beneficiaries and providing coordinated care services in April 2002. ■

### Coordinated Care To Improve Quality of Care for Chronically Ill Medicare Beneficiaries—Maine

**Project No:** 95-C-91314/01
**Project Officer:** Sid Mazumdar
**Period:** April, 2002 to March, 2006
**Funding:** $138,720
**Principal Investigator:** John LaCasse
**Award:** Cooperative Agreement
**Awardee:** Medical Care Development
11 Packwood Drive
Augusta, ME 04330

**Status:** Medical Care Development of Augusta, Maine, has implemented a rural disease management program targeting beneficiaries in Maine with congestive heart failure or post-acute myocardial infarction. The site began enrolling beneficiaries and providing coordinated care services in April 2002. ■

### Coordinated Care To Improve Quality of Care for Chronically Ill Medicare Beneficiaries—Missouri

**Project No:** 95-C-91345/01
**Project Officer:** Kathy Headen
**Period:** August, 2002 to June, 2006
**Funding:** $150,000
**Principal Investigator:** John Lynch
**Award:** Cooperative Agreement
**Awardee:** Washington University Physician Network
7425 Forsyth Boulevard, Suite 307
St. Louis, MO 63105

**Status:** Washington University of St. Louis, Missouri, with American Healthways of Nashville, Tennessee, has implemented an urban case management program targeting beneficiaries in St. Louis with various chronic conditions. The site began enrolling beneficiaries and providing coordinated care services in August 2002. ■

### Coordinated Care To Improve Quality of Care for Chronically Ill Medicare Beneficiaries—New York, NY

**Project No:** 95-C-91357/02
**Project Officer:** Dennis Nugent
**Period:** June, 2002 to May, 2006
**Funding:** $150,000
**Principal Investigator:** Nancy Mintz
**Award:** Cooperative Agreement
**Awardee:** The Jewish Home and Hospital for the Aged
120 West 106th Street
New York, NY 10025

**Status:** The Jewish Home and Hospital for the Aged has implemented an urban case management program targeting beneficiaries with various chronic conditions in New York City. The site began enrolling beneficiaries and providing coordinated care services in June 2002. ■

### Coordinated Care To Improve Quality of Care for Chronically Ill Medicare Beneficiaries—Northern California

**Project No:** 95-C-91352/02
**Project Officer:** John Pilotte
**Period:** July, 2002 to June, 2006
**Funding:** $150,000
**Principal Investigator:** Michael Cox
**Award:** Cooperative Agreement
**Awardee:** QMED, Inc.
25 Christopher Way
Eaton, NJ 07724

A and Part B and requires that the projects' payment methodology be budget neutral.

**Status:** QMED, Inc., of Laurence Harbor, New Jersey, has implemented an urban disease management program targeting beneficiaries in northern California with coronary artery disease. The site began enrolling beneficiaries and providing coordinated care services in July 2002. ■

### Coordinated Care To Improve Quality of Care for Chronically Ill Medicare Beneficiaries—Pennsylvania

**Project No:** 95-C-91360/03
**Project Officer:** Cynthia Mason
**Period:** April, 2002 to March, 2006
**Funding:** $0
**Principal Investigator:** Kenneth Coburn
**Award:** Cooperative Agreement
**Awardee:** Health Quality Partners
875 North Easton Road
Doylestown, PA 18901

**Status:** Health Quality Partners of Plumsteadville, Pennsylvania, has implemented an urban and rural disease management program targeting beneficiaries in eastern Pennsylvania with various chronic conditions. The site began enrolling beneficiaries and providing coordinated care services in April 2002. ■

### Coordinated Care To Improve Quality of Care for Chronically Ill Medicare Beneficiaries—Richmond, Virginia

**Project No:** 95-C-91319/03
**Project Officer:** Cynthia Mason
**Period:** April, 2002 to March, 2006
**Funding:** $75,448
**Principal Investigator:** Michael Matthews
**Award:** Cooperative Agreement
**Awardee:** CenVaNet, Inc.
2201 West Broad Street, Suite 202
Richmond, VA 23220

**Status:** CenVaNet, Incorporated, of Richmond, Virginia, has implemented an urban case management program targeting beneficiaries with various chronic conditions in the metropolitan Richmond area. The site began enrolling beneficiaries and providing coordinated care services in April 2002. ■

### Coordinated Care To Improve Quality of Care for Chronically Ill Medicare Beneficiaries—South Dakota

**Project No:** 95-C-91362/08
**Project Officer:** Sid Mazumdar
**Period:** June, 2002 to May, 2006
**Funding:** $0
**Principal Investigator:** David Kuper
**Award:** Cooperative Agreement
**Awardee:** Avera McKennan Hospital
800 East 21st Street
Sioux Falls, SD 57105

**Status:** Avera McKennan Hospital of Sioux Falls, South Dakota, has implemented a rural disease management program targeting beneficiaries in South Dakota, Iowa, and Minnesota. The site began enrolling beneficiaries and providing coordinated care services in June 2002. ■

### Coordinated Care To Improve Quality of Care for Chronically Ill Medicare Beneficiaries—University of Maryland

**Project No:** 95-C-91349/03
**Project Officer:** Dennis Nugent
**Period:** June, 2002 to May, 2006
**Funding:** $0
**Principal Investigator:** Stephen Gottlieb
**Award:** Cooperative Agreement
**Awardee:** University of Maryland School of Medicine
22 South Greene Street
Baltimore, MD 21201-1595

**Status:** The University of Maryland School of Medicine has implemented an urban disease management program targeting beneficiaries with congestive heart failure in Baltimore, Maryland. The site began enrolling beneficiaries and providing coordinated care services in June 2002. ■

### Coordinated Care To Improve Quality of Care for Chronically Ill Medicare Beneficiaries—Washington, DC

**Project No:** 95-C-91367/03
**Project Officer:** John Pilotte
**Period:** June, 2002 to May, 2006
**Funding:** $0
**Principal Investigator:** James Welsh
**Award:** Cooperative Agreement
**Awardee:** Georgetown University
1707 L Street, NW, Suite 900
Washington, DC 20036

**Status:** Georgetown University Medical Center in Washington, DC, has implemented a program providing disease management services for Medicare FFS beneficiaries with congestive heart failure residing in the District of Columbia and suburban Maryland. The site began enrolling beneficiaries and providing coordinated care services in June 2002. ■

### Implementation Support for the Medicare Coordinated Care Demonstration

**Project No:** HCFA-00-1223
**Project Officer:** Cynthia Mason
**Period:** September, 2000 to March, 2005
**Funding:** $1,768,000
**Principal Investigators:** Denise Marshall and Bradley Smith
**Award:** GSA Order
**Awardee:** BearingPoint
1676 International Drive
McLean,VA 22102-4828

**Description:** This demonstration tests whether coordinated care programs can improve medical treatment plans, reduce avoidable hospital admissions, and promote other desirable outcomes among beneficiaries who constitute a small proportion of the Medicare fee-for-service (FFS) population but account for a major proportion of Medicare expenditures. Fifteen sites were selected to participate in this 4-year demonstration project to provide case management and disease management services to Medicare FFS beneficiaries with complex chronic conditions. This project is allowing CMS to test a wide range of programs aimed at reducing costs and increasing quality of care for chronically ill Medicare FFS beneficiaries. The Balanced Budget Act of 1997 requires that the projects focus on chronically ill Medicare FFS beneficiaries who are eligible for both Medicare Part A and Part B and requires that the projects' payment methodology be budget neutral.

**Status:** The project sites began implementing the project in April 2002. By September 2002, all 15 sites had initiated enrollment. The first Report to Congress is scheduled to be released in the spring of 2004. ■

### Evaluation of Disease Management Demonstration

**Project No:** 500-00-0033/03
**Project Officer:** Lorraine Johnson
**Period:** September, 2003 to September, 2004
**Funding:** $321,277
**Principal Investigator:** Robert Schmitz
**Award:** Task Order
**Awardee:** Mathematica Policy Research (Princeton)
600 Alexander Park
PO Box 2393
Princeton, NJ 08543-2393

**Description:** The purpose of this project is to evaluate the effectiveness of Medicare Capitated Disease Management Demonstration for beneficiaries with chronic medical conditions such as stroke, congestive heart failure, and diabetes; people who receive both Medicare and Medicaid (dual eligibles); or frail elderly patients who would benefit from a greater coordination of services. This demonstration uses disease management interventions and payment for services based on full capitation with risk sharing options to (1) improve the quality of services furnished to specific eligible beneficiaries, including the dual eligible and frail elderly; (2) manage expenditures under Part A and Part B of the Medicare program; and (3) encourage the formation of specialty plans that market directly to Medicare's sickest beneficiaries.

**Status:** Project is on track and proceeding as planned. ■

### Payment Development, Implementation, and Monitoring Support for the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) Disease Management Demonstrations

**Project No:** 500-00-0036/01
**Project Officer:** J. Donald Sherwood
**Period:** September, 2002 to September, 2007
**Funding:** $435,557
**Principal Investigator:** C. William Wrightson
**Award:** Task Order
**Awardee:** Actuarial Research Corporation
5513 Twin Knolls Road, Suite 213
Columbia, MD 21045

**Description:** The purpose of this task is to support CMS in implementing a demonstration project in three

or more sites to provide disease management services to Medicare beneficiaries with advanced stages of congestive heart failure, coronary heart disease, and/or diabetes. Specifically, this project (1) provides general technical support in the analysis of rate proposals and assistance in calculating the appropriate payment rates (both initial and annual updates) for the selected projects; (2) educates demonstration sites regarding payment calculations, billing processes and requirements, and budget neutrality requirements; (3) monitors payments and Medicare expenditures to assure budget neutrality, including designing data collection processes for use in collecting and warehousing necessary data elements from sites and CMS administrative records for assessing performance; and (4) performs financial analysis to assist in the financial settlement and reconciliation.

**Status:** This project is in the second year. ■

### Evaluation of End Stage Renal Disease (ESRD) Disease Management (DM)

**Project No:** 500-00-0028/02
**Project Officer:** Joel Greer
**Period:** September, 2003 to September, 2004
**Funding:** $2,192,652
**Principal Investigator:** Frederich Port, M.D.
**Award:** Task Order
**Awardee:** University Renal Research and Education Association
315 West Huron, Suite 260
Ann Arbor, MI 48103

**Description:** This task order is for an independent evaluation of the ESRD DM Demonstration (DMD) that will examine case-mix, patient satisfaction, outcomes, quality of care, and costs and payments. The Request for Proposals for providers to participate in the DMD was published in the Federal Register on June 4, 2003. The DMD will enroll Medicare beneficiaries with ESRD into fully or partially capitated ESRD disease management organizations. It is anticipated that the awards for the DM sites will be made in the third quarter of FY 2004. The evaluation contractor will work with the DM sites to collect and analyze data to measure clinical, quality-of-life, and economic outcomes. The evaluation is currently funded for 1 year (until 9/27/04) with up to four additional 1-year phases to be awarded. When the DM sites are selected, the evaluation team will work with them to design and implement data collection instruments and mechanisms.

**Status:** The evaluator is waiting for the DM sites to begin operation. ■

### Evaluation of Programs of Coordinated Care and Disease Management

**Project No:** 500-95-0047/09
**Project Officer:** Carol Magee
**Period:** September, 2000 to September, 2005
**Funding:** $3,018,839
**Principal Investigator:** Randall S. Brown, Ph.D.
**Award:** Task Order
**Awardee:** Mathematica Policy Research (DC)
600 Maryland Avenue, SW
Suite 550
Washington, DC 20024-2512

**Description:** This 5-year evaluation project will describe and assess, individually and summarily, 16 congressionally mandated Medicare Coordinated Care Demonstration Programs, each providing a particular set of coordinated care interventions to fee-for-service (FFS) Medicare beneficiaries with one or more selected chronic illnesses (e.g., diabetes, chronic obstructive pulmonary disease, asthma, hypertension, hyperlipidemia, stroke, renal or hepatic disease, coronary artery disease, cancer). Demonstration of the effectiveness of programs of care coordination or management has historically been complicated not only by wide variations in program staff, funding mechanisms, interventions, and stated goals, but by the evaluators' definition(s) of effectiveness. The Balanced Budget Act of 1997 mandated demonstrations in separate program sites to implement approaches to coordinated care of chronic illnesses, along with an independent evaluation, for the Centers for Medicare & Medicaid Services (CMS) to investigate the potential of care coordination and/or case management to improve care quality and control costs in the Medicare FFS Program. An evaluation of best practices in coordinated care and a study of demonstration design options were conducted. The 16 CMS-funded demonstration programs being studied as a part of this evaluation vary widely with respect to the demographics, medical and social situations of the target population, intensity of services offered, interventions under study, type(s) of health care professionals delivering the interventions, and other factors. Each demonstration program has a randomized design, with a treatment arm and a "usual care" arm. The evaluation can thus test each unique program's effects upon patient outcome(s)/well-being, patient satisfaction, provider behavior and satisfaction, and Medicare claims—attributable to particular methods of managing care in the FFS Medicare environment and as compared to the respective "usual care," nonintervention patient group.

The overall goals of this evaluation are to identify those characteristics of the programs of coordinated care under study that have the greatest impact on health care quality and cost and to identify the target populations

most likely to benefit from such programs. In addition to analysis plans specific to each program/site, the evaluation contractor will conduct a process analysis to describe the interventions in detail, with a key goal of assessing what factors account for program success or failure. The study will include successive case studies of each of the 16 sites, interim and final site-specific reports, two interim summary reports, two Reports to Congress (based upon the interim summary reports), and a final summary report.

**Status:** Subsequent to receiving the Office of Management and Budget approval, the evaluation contractor has been holding initial conference calls and then visiting the majority of the 16 Demonstration sites over the past 2 years to amass data concerning their programs as actually implemented at 3 months into the demonstrations and their status as of 12 months post startup. A number of these individual site reports have been completed and are available from the evaluation project officer. The (confidential) First Interim Summary report and the Draft of the First Report to Congress have just been completed. There is wide disparity, as expected, in the enrollment success of the various sites, and locating and convincing patients to enroll has been harder overall than anticipated. The first of two waves of patient satisfaction and status telephone CATI interviews (n=3,315) has been completed in October for patients 7 to 12 months following their respective enrollment. Similarly, the first of two waves of physician provider interviews (n=350) was completed in October. ■

### Evaluation of Programs of Disease Management (Phase I and Phase II)

**Project No:** 500-00-0033/02
**Project Officer:** Lorraine Johnson
**Period:** September, 2002 to September, 2007
**Funding:** $1,908,308
**Principal Investigator:** Randall S. Brown, Ph.D.
**Award:** Task Order
**Awardee:** Mathematica Policy Research (DC)
600 Maryland Avenue, SW
Suite 550
Washington, DC 20024-2512

**Description:** The objective of the evaluation is to assess the effectiveness of disease management programs for serious chronic medical conditions such as advanced stage diabetes and congestive heart failure. Although the participating demonstration sites may also vary by classification of disease severity, the availability of a pharmacy benefit, population targeted, scope of patient care covered, type of comparison group and other factors, they will have the common goal of improving quality and reducing cost of health care received by chronically ill Medicare beneficiaries through specific services targeted to the management of a particular medical condition. The evaluation will study the independent effects of both the disease management program and a drug benefit, as well as any interaction between the two.

**Status:** The project is under way. ■

### Innovations in Health Care

**Project No:** 18-C-91677/04
**Project Officer:** Dennis Nugent
**Period:** September, 2001 to September, 2002
**Funding:** $775,833
**Principal Investigator:** Gary Stiles
**Award:** Cooperative Agreement
**Awardee:** Duke University Health System
DUMC 3681
Durham, NC 27710

**Description:** This is a three-phase study. First, it will develop policy case studies in strategic health planning designed to highlight the importance of integrative disease management and strategic health planning for patients with three complex and chronic diseases (congestive heart failure, diabetes, and depression). A policy case study on the management of obstetric care at the time of delivery will also be conducted. The second will summarize the evidences and develop an evidence-based approach to patient-specific strategic health planning that serves to link risks and behaviors to action items unique for each patient independent of any particular disease. The plans will incorporate a broad-based integrative approach including strategies regarding nutrition, exercise, stress management, and social support. The project will then implement strategic health planning in a defined patient cohort. Finally, the project will be a cost and policy analysis of secondary prevention for patients with coronary artery disease. The objectives here will be to maximize the appropriate use of secondary prevention for this disease in Medicare patients, measure the financial impact on hospitals, providers, and patients of improving secondary prevention, and examine the effectiveness of strategies to improve adherence of physicians and patients to secondary prevention.

**Status:** The project is under way. ■

### Evaluation of the Informatics, Telemedicine, and Education Demonstration

**Project No:** 500-95-0055/05
**Project Officer:** Carol Magee
**Period:** September, 2000 to July, 2004
**Funding:** $1,419,493
**Principal Investigators:** David West and Judith Wooldridge
**Award:** Task Order
**Awardees:** Mathematica Policy Research (Princeton)
600 Alexander Park
PO Box 2393
Princeton, NJ 08543-2393

Urban Institute
2100 M Street, NW
Washington, DC 20037

**Description:** The Balanced Budget Act of 1997 mandates a single, 4-year demonstration project using an eligible health care provider telemedicine network. The demonstration involves the application of high-capacity computing and advanced telemedicine networks to the task of improvement of primary care and prevention of health complications in Medicare beneficiaries with diabetes mellitus. This project evaluates the impact of using telemedicine and medical informatics on improving access of Medicare beneficiaries to health care services, on reducing the costs of such services, and on improving the quality of life of beneficiaries. The Informatics, Telemedicine, and Education Demonstration project uses specially modified home computers, or home telemedicine units (HTU) linked to a Clinical Information System, and studies beneficiaries residing in medically underserved rural or medically underserved inner-city areas. The HTUs in patients' homes allow video conferencing, access to health information and medical data, in both Spanish and English. The demonstration project is being conducted as a randomized, controlled clinical trial. Impact of the telemedicine intervention on health outcomes will be evaluated by comparing health outcome measures of the intervention group to a control group.

**Status:** The project is under way. ■

### Informatics for Diabetes Education and Telemedicine (IDEATel) Demonstration

**Project No:** 95-C-90998/02
**Project Officer:** Patricia Brocato-Simons
**Period:** February, 2000 to February, 2008
**Funding:** $60,000,000
**Principal Investigator:** Steven Shea
**Award:** Cooperative Agreement
**Awardee:** Columbia University
630 West 168th Street
PH 9 East, Room 105
New York, NY 10706

**Description:** The project focuses on Medicare beneficiaries with diabetes because of the high prevalence, cost, and complexity of this condition. It also focuses on beneficiaries living in federally designated, medically underserved areas in order to demonstrate that obstacles to bridging the "digital divide" in health care are not intrinsic to the targeted population. The project involves a consortium of health care delivery organizations in New York City (urban component) and upstate New York (rural component), industry partners who are providing hardware, software, technology, and communication services, and the American Diabetes Association, which is providing the educational Web site for the project. The consortium is led by Columbia University. Intervention participants receive a home telemedicine unit that facilitates uploading of clinical data, interaction with a nurse case manager, and patient education.

**Status:** The first 9 months of the project were devoted to technical implementation, field testing, personnel training, and development of the evaluation instruments and procedures. Subject enrollment began in the latter part of 2000. As of September 2002, recruitment was completed and approximately 1,665 beneficiaries were enrolled and randomized overall acceptability of the home telemedicine unit among participants was positive. The experience to date indicates that large-scale home telemedicine as a strategy for disease management is technically feasible, can be performed in a fashion that meets current requirements for health care data security and the Health Insurance Portability and Accountability Act, and is highly acceptable to those who agree to participate. Regardless, this does not preclude the extent of training and reinforcement often necessary under these circumstances to elevate enrollees to an active and participatory level. Evidence does indicate that some Medicare beneficiaries living in federally designated medically underserved areas, for reasons such as language barriers, lack of education, and various other socioeconomic indications, are unable or unwilling to use computers or the World Wide Web to obtain health care information and health care services. ■

### Heart Failure Home Care

**Project No:** 18-C-91509/03
**Project Officer:** John Pilotte
**Period:** September, 2001 to September, 2004
**Funding:** $2,900,000
**Principal Investigators:** Ozlem Soran, M.D. and Arthur Feldman, M.D.
**Award:** Cooperative Agreement
**Awardee:** University of Pittsburgh Office of Research
350 Thackeray Hall
Pittsburgh, PA 15260

**Description:** This project seeks to use integrated nursing services and technology to implement daily monitoring of congestive heart failure patients in underserved populations in accordance with established clinical guidelines. The demonstration tests the clinical and economic effectiveness of the Alere Day Link Home Monitoring Device in Medicare beneficiaries from underserved population groups receiving care in community-based practices who are diagnosed with congestive heart failure and who have had a hospitalization within the last 6 months. The primary hypothesis is that the addition of this device to standard management of heart failure will reduce 6-month heart failure hospitalization rates, cardiovascular death, and length of hospital stay for heart failure.

**Status:** The site began enrollment in 2003 and has enrolled over 200 patients. ■

### Heart Failure Home Care

**Project No:** 18-C-91509/03-02
**Project Officer:** John Pilotte
**Period:** September, 2001 to September, 2005
**Funding:** $1,847,941
**Principal Investigators:** Arthur Feldman, M.D. and Ozlem Soran, M.D.
**Award:** Cooperative Agreement
**Awardee:** University of Pittsburgh Office of Research
350 Thackeray Hall
Pittsburgh, PA 15260

**Description:** This project seeks to use integrated nursing services and technology to implement daily monitoring of congestive heart failure patients in underserved populations in accordance with established clinical guidelines. The demonstration tests the clinical and economic effectiveness of the Alere Day Link Home Monitoring Device in Medicare beneficiaries from underserved population groups receiving care in community-based practices who are diagnosed with congestive heart failure and who have had a hospitalization within the last 6 months. The primary hypothesis is that the addition of this device to standard management of heart failure will reduce 6-month heart failure hospitalization rates, cardiovascular death, and length of hospital stay for heart failure.

**Status:** The project is ongoing. ■

### Medicare Case Management Demonstration for Congestive Heart Failure (CHF) and Diabetes Mellitus (DM)

**Project No:** 95-W-00078/06
**Project Officer:** Kathy Headen
**Period:** November, 2001 to November, 2004
**Funding:** $0
**Principal Investigator:** Diane Fields
**Award:** Cooperative Agreement
**Awardee:** Lovelace Health Systems
2309 Renard Place, SE
Albuquerque, NM 87106

**Description:** This demonstration tests whether a case management program can improve medical treatment plans, reduce avoidable hospital admissions, and promote other desirable outcomes among beneficiaries who constitute a small proportion of the Medicare fee-for-service (FFS) population, but account for a major proportion of Medicare expenditures. The demonstration site provides case management services to high-cost, high-risk Medicare FFS beneficiaries with CHF and DM. The project targets chronically ill Medicare beneficiaries who are eligible for both Medicare Parts A and B and requires that the project's payment methodology be budget neutral.

**Status:** The site began enrolling beneficiaries and providing case management services in November 2001. ■

### Improving Diabetes Outcomes Using the Care Model in an Urban Network

**Project No:** 18-P-91850/05-01
**Project Officer:** David Greenberg
**Period:** September, 2003 to September, 2004
**Funding:** $74,428
**Principal Investigator:** Leon Fogelfeld
**Award:** Grant
**Awardee:** Cook County Bureau of Health Services
1900 West Polk Street
Chicago, IL 60612

**Description:** This initiative will use the Care Model to improve the well-being of diabetic patients enrolled with the Cook County Bureau of Health Services by reducing complications from type 2 diabetes as well as preventing the onset of type 2 diabetes in pregnant women with gestational diabetes. Populations with the highest prevalence of the disease and significant barriers to self-management will be targeted, including underserved African Americans and Latinos with limited English proficiency. This project will provide an opportunity for the leadership team and local site-based teams to gain collective experience with the Care Model. Upon completion of the project, the Bureau will have a more highly developed, sustainable structure to support local primary care teams in overcoming barriers to adherence to clinical practice guidelines.

**Status:** The awardee has accepted all terms and conditions and recently selected a clinical director for this project. ■

### The Impact of Advanced Illness Coordinated Care (AICC) Nurse Practitioner

**Project No:** 18-P-91853/03-01
**Project Officer:** Pamela Kelly
**Period:** September, 2003 to March, 2005
**Funding:** $298,050
**Principal Investigator:** Joseph R. McClellan
**Award:** Grant
**Awardee:** Hamot Medical Center
3330 Peach Street, Suite 211
Erie, PA 16508

**Description:** The Advanced Illness Coordinated Care (AICC) demonstration project, utilizing Advanced Illness Nurse Practitioners (AIP), will implement the AICC program for patients diagnosed with advanced cancer, congestive heart failure, and chronic obstructive pulmonary disease at Hamot Medical Center. The primary objectives for the project are to increase documentation of advance directives, decrease intensive care utilization and mortalities, and decrease total health care costs for these patients with end-stage, advanced diagnoses.

**Status:** The project began in September 2003. As of January 2004, they have completed all hiring, as well as program processes, data collection forms, and database development for the project. They have begun screening patients and have identified over 100 patients who potentially qualify for the project. They have contacted about 60 of those and have enrolled over 10 patients. They have recruited far more heart failure enrollees than oncology but hope to equalize that in the near future. They have had 20 patients express interest in participating but want to wait until spring because of the weather in Pennsylvania. ■

## MEDICARE LIFESTYLE MODIFICATION PROGRAM DEMONSTRATION—PREVENTIVE MEDICINE RESEARCH INSTITUTE

The Medicare Lifestyle Modification Program Demonstration was implemented October 1, 1999, to evaluate the feasibility and cost-effectiveness of cardiovascular lifestyle modification. Sites eligible to participate in the demonstration are those licensed to the Dr. Dean Ornish Program for Reversing Heart Disease licensed by Lifestyle Advantage and the Preventive Medicine Research Institute. Sites will be able to enroll up to 1,800 Medicare Part B eligible beneficiaries who meet the clinical enrollment criteria and voluntarily elect to participate in the demonstration. The demonstration sites receive 80 percent of a negotiated fixed payment amount for a 12-month program of treatment. Sites may collect (or waive) the remaining 20 percent from the beneficiary as an enrollment fee. Claims processing and payment is managed through the Division of Demonstrations Management in the Office of Financial Management at CMS.

**Status:** On November 28, 2000, the enrollment criteria were amended to include patients with less severe cardiovascular disease. In accordance with Public Law 106-554, the Consolidated Appropriations Act of 2001, the Cardiac Wellness lifestyle program of the Mind/Body Medical Institute (M/BMI) was incorporated into the overall demonstration. The same law provided a mandate for a 4-year treatment period beginning November 13, 2000. On May 3, 2002, enrollment criteria were again amended to include patients with moderate cardiovascular disease and the demonstration enrollment period was extended to February 28, 2005, with treatment under the demonstration ending in 2006. There are currently 17 sites offering the Dr. Dean Ornish Program and 8 sites offering the Cardiac Wellness Expanded Program. ■

**Medicare Lifestyle Modification Program Demonstration—Preventive Medicine Research Institute**

**Project No:** 95-W-00131/03
**Project Officer:** Armen Thoumaian
**Period:** May, 2002 to February, 2006
**Funding:** $0
**Principal Investigator:** David Seigneur
**Award:** Waiver-Only Project
**Awardee:** Allegheny General Hospital
320 North Avenue
Pittsburgh, PA 15212

**Medicare Lifestyle Modification Program Demonstration—Preventive Medicine Research Institute**

**Project No:** 95-W-00132/03
**Project Officer:** Armen Thoumaian
**Period:** July, 2003 to February, 2006
**Funding:** $0
**Principal Investigator:** Michelle Dyer
**Award:** Waiver-Only Project
**Awardee:** DuBois Regional Medical Center
100 Hospital Avenue
DuBois, PA 15801

**Medicare Lifestyle Modification Program Demonstration—Preventive Medicine Research Institute**

**Project No:** 95-W-00133/03
**Project Officer:** Armen Thoumaian
**Period:** May, 2003 to February, 2006
**Funding:** $0
**Principal Investigator:** Randall Komacko, MPT
**Award:** Waiver-Only Project
**Awardee:** Monongahela Valley Hospital
1163 Country Club Road
Monongahela, PA 15063

**Medicare Lifestyle Modification Program Demonstration—Preventive Medicine Research Institute**

**Project No:** 95-W-00134/03
**Project Officer:** Armen Thoumaian
**Period:** October, 2002 to February, 2006
**Funding:** $0
**Principal Investigator:** Sean O'Dowd
**Award:** Waiver-Only Project
**Awardee:** Windber Medical Center
600 Somerset Avenue
Windber, PA 15963

**Medicare Lifestyle Modification Program Demonstration—Preventive Medicine Research Institute**

**Project No:** 95-W-00135/03
**Project Officer:** Armen Thoumaian
**Period:** June, 2002 to February, 2006
**Funding:** $0
**Principal Investigator:** Joe Slavic
**Award:** Waiver-Only Project
**Awardee:** Howard Long Wellness Center at Wheeling Hospital
800 Medical Park
Wheeling, WV 26003

**Medicare Lifestyle Modification Program Demonstration—Preventive Medicine Research Institute**

**Project No:** 95-W-00136/07
**Project Officer:** Armen Thoumaian
**Period:** June, 2002 to February, 2006
**Funding:** $0
**Principal Investigator:** Sandy Barta, MS, RN
**Award:** Waiver-Only Project
**Awardee:** Alegent Bergan Mercy Medical Center
7710 Mercy Road, BMPC, LL
Omaha, NE 68122

**Medicare Lifestyle Modification Program Demonstration—Preventive Medicine Research Institute**

**Project No:** 95-W-00137/03
**Project Officer:** Armen Thoumaian
**Period:** May, 2002 to February, 2006
**Funding:** $0
**Principal Investigator:** Ed Haver
**Award:** Waiver-Only Project
**Awardee:** Charleston Area Medical Center
3200 MacCorkle Avenue, SE
Charleston, WV 25304

**Medicare Lifestyle Modification Program Demonstration—Preventive Medicine Research Institute**

**Project No:** 95-W-00138/03
**Project Officer:** Armen Thoumaian
**Period:** April, 2002 to February, 2006
**Funding:** $0
**Principal Investigator:** Dana DeJarnett
**Award:** Waiver-Only Project
**Awardee:** Wellness Center at City Hospital
2000 Foundation Way, Suite 1200
Martinsburg, WV 25401

**Medicare Lifestyle Modification Program Demonstration—Preventive Medicine Research Institute**

**Project No:** 95-W-00139/03
**Project Officer:** Armen Thoumaian
**Period:** March, 2002 to February, 2006
**Funding:** $0
**Principal Investigator:** Toni Marascio
**Award:** Waiver-Only Project
**Awardee:** United Hospital Center
#3 Hospital Plaza
Clarksburg, WV 26301

**Medicare Lifestyle Modification Program Demonstration—Preventive Medicine Research Institute**

**Project No:** 95-W-00140/03
**Project Officer:** Armen Thoumaian
**Period:** November, 2002 to February, 2006
**Funding:** $0
**Principal Investigator:** Mona Wilson
**Award:** Waiver-Only Project
**Awardee:** St. Mary's Medical Center
2900 1st Avenue
Huntington, WV 25702

**Medicare Lifestyle Modification Program Demonstration—Preventive Medicine Research Institute**

**Project No:** 95-W-00141/03
**Project Officer:** Armen Thoumaian
**Period:** November, 2002 to February, 2006
**Funding:** $0
**Principal Investigator:** Cindy Gillaspie
**Award:** Waiver-Only Project
**Awardee:** Princeton Community Hospital
PO Box 1369
Princeton, WV 24740-1369

**Medicare Lifestyle Modification Program Demonstration—Preventive Medicine Research Institute**

**Project No:** 95-W-00142/03
**Project Officer:** Armen Thoumaian
**Period:** June, 2003 to February, 2006
**Funding:** $0
**Principal Investigator:** Joyan L. Urda
**Award:** Waiver-Only Project
**Awardee:** Jameson Health System
1211 Wilmington Avenue, Room 430
New Castle, PA 16105

**Medicare Lifestyle Modification Program Demonstration—Preventive Medicine Research Institute**

**Project No:** 95-W-00143/07
**Project Officer:** Armen Thoumaian
**Period:** May, 2001 to February, 2006
**Funding:** $0
**Principal Investigator:** Thomas McLeod
**Award:** Waiver-Only Project
**Awardee:** Good Samaritan Health Systems
10 East 31st Street
PO Box 1990
Kearney, NE 68848-1990

**Medicare Lifestyle Modification Program Demonstration—Preventive Medicine Research Institute**

**Project No:** 95-W-00144/03
**Project Officer:** Armen Thoumaian
**Period:** May, 2002 to February, 2006
**Funding:** $0
**Principal Investigator:** David Harshbarger
**Award:** Waiver-Only Project
**Awardee:** West Virginia University Hospital
Medical Center Drive
Morgantown, WV 26506-8120

**Medicare Lifestyle Modification Program Demonstration—Preventive Medicine Research Institute**

**Project No:** 95-W-00145/05
**Project Officer:** Armen Thoumaian
**Period:** April, 2000 to February, 2006
**Funding:** $0
**Principal Investigator:** Jennifer Tucek
**Award:** Waiver-Only Project
**Awardee:** Swedish American Heart and
Vascular Center
209 Ninth Street
Rockford, IL 61104

**Medicare Lifestyle Modification Program Demonstration—Mind/Body Medical Institute**

**Project No:** 95-W-00146/01
**Project Officer:** Armen Thoumaian
**Period:** September, 2001 to February, 2006
**Funding:** $0
**Principal Investigator:** Barbara Haydon
**Award:** Waiver-Only Project
**Awardee:** Care New England Wellness Center
2191 Post Road
Warwick, RI 02886

**Medicare Lifestyle Modification Program Demonstration—Mind/Body Medical Institute**

**Project No:** 95-W-00147/03
**Project Officer:** Armen Thoumaian
**Period:** October, 2002 to February, 2006
**Funding:** $0
**Principal Investigator:** Simin A. Mohit
**Award:** Waiver-Only Project
**Awardee:** Bon Secours—St. Mary's Hospital
150 Kingsley Lane
Norfolk, VA 23501

**Medicare Lifestyle Modification Program Demonstration—Mind/Body Medical Institute**

**Project No:** 95-W-00148/03
**Project Officer:** Armen Thoumaian
**Period:** January, 2002 to February, 2006
**Funding:** $0
**Principal Investigator:** Brenda Alexander
**Award:** Waiver-Only Project
**Awardee:** Bon Secours—Maryview Hospital
3636 High Street
Portsmouth, VA 23707

**Medicare Lifestyle Modification Program Demonstration—Mind/Body Medical Institute**

**Project No:** 95-W-00149/10
**Project Officer:** Armen Thoumaian
**Period:** March, 2003 to February, 2006
**Funding:** $0
**Principal Investigator:** Dr. Mary Dean
**Award:** Waiver-Only Project
**Awardee:** MultiCare Health System
Cardiac Wellness Program
Tacoma, WA 98405

### Medicare Lifestyle Modification Program Demonstration—Mind/Body Medical Institute

**Project No:** 95-W-00150/01
**Project Officer:** Armen Thoumaian
**Period:** June, 2001 to February, 2006
**Funding:** $0
**Principal Investigator:** Aggie Casey
**Award:** Waiver-Only Project
**Awardee:** Mind/Body Medical Institute
824 Boylston Street
Chestnut Hill, MA 02467

### Medicare Lifestyle Modification Program Demonstration—Preventive Medicine Research Institute

**Project No:** 95-W-00151/03
**Project Officer:** Armen Thoumaian
**Period:** August, 2003 to February, 2006
**Funding:** $0
**Principal Investigator:** Walter Horner
**Award:** Waiver-Only Project
**Awardee:** Hamot Medical Center
3330 Peach Street, Suite 211
Erie, PA 16508

### Medicare Lifestyle Modification Program Demonstration—Continuous Quality Monitoring

**Project No:** 500-99-MD02/SS05
**Project Officer:** Armen Thoumaian
**Period:** July, 1999 to March, 2006
**Funding:** $1,559,912
**Principal Investigator:** Thomas Schaefer
**Award:** PRO Contract Special Study
**Awardee:** Delmarva Foundation for Medical Care
9240 Centreville Road
Easton, MD 21601-7098

**Description:** The Medicare Lifestyle Modification Program Demonstration was implemented October 1, 1999, to evaluate the feasibility and cost-effectiveness of cardiovascular lifestyle modification. Sites eligible to participate in the demonstration are those licensed to provide one of two nationally known treatment models: the Dr. Dean Ornish Program for Reversing Heart Disease licensed by Lifestyle Advantage and the Preventive Medicine Research Institute, or the Cardiac Wellness Expanded Program of Dr. Herbert Benson licensed by the Mind/Body Medical Institute. Sites offering either model will be able to enroll up to 1,800 Medicare Part B eligible beneficiaries who meet the clinical enrollment criteria and voluntarily elect to participate in the demonstration. The demonstration sites receive 80 percent of a negotiated fixed payment amount for a 12-month program of treatment. Sites may collect (or waive) the remaining 20 percent from the beneficiary as an enrollment fee. Claims processing and payment is managed through the Division of Demonstrations Management in the Office of Financial Management at CMS. This project provides continuous quality monitoring of the demonstration sites to assure the health and safety of participating Medicare patients.

**Status:** On November 28, 2000, the enrollment criteria were amended to include patients with less severe cardiovascular disease. In accordance with Public Law 106-554, the Consolidated Appropriations Act of 2001, the Cardiac Wellness lifestyle program of the Mind/Body Medical Institute was incorporated into the overall demonstration. The same law provided a mandate for a 4-year treatment period beginning November 13, 2000. On May 3, 2002, enrollment criteria were again amended to include patients with moderate cardiovascular disease and the demonstration enrollment period was extended to February 28, 2005, with treatment under the demonstration ending in 2006. There are currently 17 sites offering the Dr. Dean Ornish Program and 8 sites offering the Cardiac Wellness Expanded Program. The Quality Monitoring and Review contract began in July 1999. In September 2002, the contract was extended with additional funds to July 2006 commensurate with the extension of the demonstration treatment period. ■

### Medicare Lifestyle Modification Program Demonstration Evaluation

**Project No:** 500-95-0060/02
**Project Officer:** Armen Thoumaian
**Period:** September, 2000 to May, 2007
**Funding:** $3,795,076
**Principal Investigators:** Donald Shepard and William B. Stanton
**Award:** Task Order
**Awardee:** Institute for Health Policy
Heller Graduate School
Brandeis University
415 South Street
PO Box 9110
Waltham, MA 02254-9110

**Description:** This project evaluates the health outcomes and cost-effectiveness of the Medicare Lifestyle Modification Program Demonstration for Medicare beneficiaries with coronary artery disease (CAD). The demonstration tests the feasibility and cost-effectiveness of providing payment for cardiovascular lifestyle modification program services to Medicare beneficiaries. The goal of the evaluation is to provide an

assessment of the health benefit and cost-effectiveness of treatment for Medicare beneficiaries with CAD who enroll in the 12-month cardiovascular lifestyle modification programs at the demonstration sites. The evaluation of the demonstration assesses the overall performance of the demonstration sites, including the quality of health care delivery over the course of the demonstration period. The evaluation also assesses the use of systems for administration, claims processing and payment, and the routine monitoring of quality of care. The evaluation consists, in part, of a pre/post quasi-experimental, matched pairs design with a 1-year followup of a maximum of 3,600 treatment enrollees and 3,600 comparison group subjects. Data collection is expected to include diagnostic and clinical outcome information from treatment and control patient physicians and the treatment program, supplemented by medical record review, patient surveys, program case studies, and Medicare claims data. Allowances are made to provide additional payments to the patients' physicians for information reporting.

**Status:** In September 2001, the evaluation was expanded to include a longer followup period of treatment and control patients, and to include a critical review of literature of all lifestyle modification programs worldwide. In September 2003, following the implementation of new enrollment criteria, the contract was expanded to include another matched control group of beneficiaries who have had cardiac rehabilitation as part of traditional treatment. In addition, the evaluation was expanded to include a study of the Medicare cardiac rehabilitation benefit. ■

### Medicare Lifestyle Modification Program Demonstration—Continuous Quality Monitoring and Review

**Project No:** 500-99-IA41
**Project Officer:** Armen Thoumaian
**Period:** July, 1999 to February, 2006
**Funding:** $1,559,912
**Principal Investigator Award:** PRO Contract Special Study
**Awardee:** Delmarva Foundation for Medical Care
9240 Centreville Road
Easton, MD 21601-7098

**Description:** The Medicare Lifestyle Modification Program Demonstration was implemented October 1, 1999, to evaluate the feasibility and cost-effectiveness of cardiovascular lifestyle modification. Sites eligible to participate in the demonstration are those licensed to provide one of two nationally known treatment models: the Dr. Dean Ornish Program for Reversing Heart Disease licensed by Lifestyle Advantage and the Preventive Medicine Research Institute, or the Cardiac Wellness Expanded Program of Dr. Herbert Benson licensed by the Mind/Body Medical Institute. Sites offering either model will be able to enroll up to 1,800 Medicare Part B eligible beneficiaries who meet the clinical enrollment criteria and voluntarily elect to participate in the demonstration. The demonstration sites receive 80 percent of a negotiated fixed payment amount for a 12-month program of treatment. Sites may collect (or waive) the remaining 20 percent from the beneficiary as an enrollment fee. Claims processing and payment is managed through the Division of Demonstrations Management in the Office of Financial Management at CMS. This project provides continuous quality monitoring of the demonstration sites to assure the health and safety of participating Medicare patients.

**Status:** On November 28, 2000, the enrollment criteria were amended to include patients with less severe cardiovascular disease. In accordance with Public Law 106-554, the Consolidated Appropriations Act of 2001, the Cardiac Wellness lifestyle program of the Mind/Body Medical Institute (M/BMI) was incorporated into the overall demonstration. The same law provided a mandate for a 4-year treatment period beginning November 13, 2000. On May 3, 2002, enrollment criteria were again amended to include patients with moderate cardiovascular disease and the demonstration enrollment period was extended to February 28, 2005, with treatment under the demonstration ending in 2006. There are currently 17 sites offering the Dr. Dean Ornish Program and 8 sites offering the Cardiac Wellness Expanded Program. The Quality Monitoring and Review contract began in July 1999. In September 2002, the contract was extended with additional funds to July 2006 commensurate with the extension of the demonstration treatment period. ■

### A Comprehensive Model of Practical and Emotional Support Service

**Project No:** 18-P-91860/09-01
**Project Officer:** Shannon Metzler
**Period:** September, 2003 to September, 2004
**Funding:** $322,888
**Principal Investigator:** Hywel Sims
**Award:** Grant
**Awardee:** The Breast Cancer Fund
2107 O'Farrell Street
San Francisco, CA 94115

**Description:** The Breast Cancer Fund (TBCF) and Shanti, a San Francisco-based nonprofit organization, have joined together with a consortium of breast cancer and HIV/AIDS service providers to create Lifelines. The goal of this program is to increase the quality of

life for underserved women living with breast cancer by addressing barriers that impact their ability to access care and treatment. The goal of this grant is to increase capacity to reach additional women in the Bay Area, where breast cancer rates are significantly higher than the rest of the country. The additional resources will enable Lifelines to expand into a national model that raises the standard of health care for poor and uninsured women with breast cancer nationwide, building on the service delivery systems that are already in place in each community.

**Status:** The budget period of the project is scheduled for 9/01/03–8/31/04, with a financial status report due to CMS no later than 90 days after the end of the budget period. A written progress report is due to CMS no later than 30 days after the end of the budget period. The CMS project officer spoke with the grantee regarding financial issues and referred him to the CMS grants officer for any questions regarding funding. ■

## CONSUMER DIRECTED DURABLE MEDICAL EQUIPMENT DEMONSTRATION PROJECT

This demonstration supports the U.S. Department of Education Center for Independent Living projects. A Center for Independent Living is a local consumer-led organization devoted to helping people with disabilities live and work within their communities. This CMS demonstration helps Medicare beneficiaries with disabilities exercise greater choice and control in meeting their personal needs for wheelchairs and other durable medical equipment (DME). Goals of the projects include treating individuals with disabilities with dignity, providing the necessary tools to live and work more independently, and assisting people with disabilities to be successfully employed. CMS and the Department of Education will share any innovations and best practices identified under the demonstration project.

**Status:** The project is under way. ■

### Consumer Directed Durable Medical Equipment Demonstration Project

**Project No:** 95-C-90917/01
**Project Officer:** Paul Mendelsohn
**Period:** September, 2000 to August, 2004
**Funding:** $150,000
**Principal Investigator:** Kathryn Goodwin
**Award:** Cooperative Agreement
**Awardee:** Alpha One Center for Independent Living
127 Main Street
South Portland, ME 04106

### Consumer Directed Durable Medical Equipment Demonstration Project

**Project No:** 95-C-90921/01
**Project Officer:** Paul Mendelsohn
**Period:** September, 2000 to August, 2004
**Funding:** $150,000
**Principal Investigator:** Robert Bailey
**Award:** Cooperative Agreement
**Awardee:** Center for Living and Working
484 Main Street, Suite 345
Worchester, MA 01668

### Consumer Directed Durable Medical Equipment Demonstration Project

**Project No:** 95-C-90922/06
**Project Officer:** Michael Henesch
**Period:** September, 2000 to August, 2004
**Funding:** $150,000
**Principal Investigator:** Carla Lawson
**Award:** Cooperative Agreement
**Awardee:** Ability Resources Inc.
823 South Detroit, Suite 110
Tulsa, OK 74120

### Consumer Directed Durable Medical Equipment Demonstration Project

**Project No:** 95-C-90916/03
**Project Officer:** Paul Mendelsohn
**Period:** September, 2000 to August, 2004
**Funding:** $150,000
**Principal Investigator:** Amy VanDyke
**Award:** Cooperative Agreement
**Awardee:** Center for Independent Living of Southwest Pennsylvania
7110 Penn Avenue
Pittsburgh, PA 15208-2434

### Evaluation of Wheel Chair Purchasing in the Consumer-Directed Durable Medical Equipment (CD-DME) Demonstration and Other Fee-for-Service and Managed Care Settings

**Project No:** 500-00-0032/06
**Project Officer:** William Clark
**Period:** September, 2002 to September, 2004
**Funding:** $294,852
**Principal Investigator:** Debra Frankel
**Award:** Task Order
**Awardee:** Abt Associates, Inc.
55 Wheeler Street
Cambridge, MA 02138

**Description:** The purpose of this task order is to conduct a preliminary case-study evaluation of a four-site initiative. The descriptive evaluation will compare and contrast the purchasing of wheelchair equipment in these sites with those utilized in fee-for-service and in managed care models that serve people with disabilities. The study will propose further evaluation design options for CMS consideration and related feasibility studies of other DME. This initiative tests, at a local level, an important collaboration between the Department of Health and Human Services and the Department of Education intended to improve beneficiary access and satisfaction with the purchase and maintenance of wheelchair equipment.

**Status:** A case study report on the first year of project implementation has been accepted. Evaluators are conducting site visits at demonstration sites and managed care demonstration sites for people with disabilities who often purchase wheelchair equipment. ■

### Increasing Access to Health Care for Bucks County Residents

**Project No:** 18-P-91506/03-01
**Project Officer:** Carol Magee
**Period:** September, 2001 to September, 2004
**Funding:** $1,843,000
**Principal Investigator:** Sally Fabian
**Award:** Grant
**Awardee:** Bucks County Health Improvement Project, Inc.
1201 Langhorne-Newton Road
Langhorne, PA 19047

**Description:** The project is entirely directed toward increasing access to health care for targeted vulnerable populations. Five of the Bucks County Health Improvement Project programs are already operating and will expand services to include patients in need of dental network, medication assistance, State Children's Health Insurance Program (SCHIP) outreach, adolescent mental health counseling, and influenza vaccination. A sixth program will be a new service facility consisting of two community health care clinics for low-income adults and seniors in the lower county area. Together, these six new or expanded program services will target vulnerable subgroups of all ages. Quantitative and descriptive data are to be collected. This service-delivery expansion program is congressionally mandated.

**Status:** The project is under way. ■

### Increasing Access to Health Care for Bucks County Residents

**Project No:** 18-C-91506/03-02
**Project Officer:** Carol Magee
**Period:** September, 2002 to September, 2004
**Funding:** $2,339,750
**Principal Investigator:** Sally Fabian
**Award:** Grant
**Awardee:** Bucks County Health Improvement Project, Inc.
1201 Langhorne-Newton Road
Langhorne, PA 19047

**Description:** Refer to Project 18-P-91506/03-01 for all information regarding the 3-year Bucks County grant plus the supplemental funding (18-C-91506/3-02) awarded in the last 2 years.

**Status:** Refer to Project 18-P-91506/03-01 for all information regarding the 3-year Bucks County grant plus the supplemental funding (18-C-91506/3-02) awarded in the last 2 years. ■

### Aging in Place: A New Model for Long-Term Care

**Project No:** 18-C-91036/07
**Project Officer:** Melvin Ingber
**Period:** June, 1999 to June, 2004
**Funding:** $2,000,000
**Principal Investigator:** Karen Dorman Marek
**Award:** Cooperative Agreement
**Awardee:** Curators of the University of Missouri, Office of Sponsored Program Administration
University of Missouri–Columbia
Sinclair School of Nursing
310 Jesse Hall
Columbia, MO 65211

**Description:** The goal of the Aging in Place model of care for frail elderly is to allow elders to remain in their homes as they age, rather than requiring frequent moves to allow for more intensive care if and when it becomes necessary. Although a planned element of the program is a new senior housing development, the program currently targets elderly residents of existing congregate housing.

**Status:** As a result of changes to the study plan, the applicant requested an increase in the first-year award with a corresponding reduction in the Years 2–4 awards and no change in the total budget. This change was approved. ■

### A Public-Private Partnership To Promote Reverse Mortgages for Long-Term Care

**Project No:** 18-P-91844/03-01
**Project Officer:** Tom Kornfield
**Period:** September, 2003 to May, 2004
**Funding:** $295,000
**Principal Investigators:** James P. Firman and Barbara Stucki
**Award:** Grant
**Awardee:** The National Council on the Aging
300 D Street, SW
Washington, DC 20024

**Description:** This project combines research, consumer surveys, and discussions with experts to identify cost-effective government interventions and other incentives that can facilitate the use of reverse mortgages by the elderly to finance long-term care through the purchase of long-term care insurance or long-term care services. Reverse mortgages are a special type of loan that allows people age 62 or over to convert equity in their home into cash.

**Status:** An expert panel consisting of members of government, industry, and nonprofit organizations met in October 2003 and identified a list of barriers to the adoption of reverse mortgages. The project team, based on additional discussions with expert panel members, is narrowing this list to identify the 5 or 10 barriers that are estimated to have the greatest impact on the use of reverse mortgages. The team will then evaluate these barriers and identify potential solutions and will conduct a survey to determine how consumers might respond to these solutions. The final report will contain an analysis of the reverse mortgage market, including the size of potential market segments, the results of the consumer survey, a discussion of key barriers to the adoption of reverse mortgages and potential solutions, and an assessment of the impact of alternative reverse mortgage solutions on future Medicare and Medicaid enrollment and expenditures. ■

### American Indian/Alaska Native (AI/AN) Eligibility and Enrollment in Medicaid, the State Children's Health Insurance (SCHIP), and Medicare

**Project No:** 500-00-0037/05
**Project Officers:** Linda Greenberg and Arthur Meltzer
**Period:** September, 2001 to November, 2003
**Funding:** $898,353
**Principal Investigators:** Mary Laschober and Kathryn Langwell
**Award:** Task Order
**Awardee:** BearingPoint
1676 International Drive
McLean, VA 22102-4828

**Description:** The primary objectives of this project—conducted jointly by Project HOPE Center for Health Affairs, BearingPoint Consulting, and Social and Scientific Systems, with assistance from six AI/AN consultants and a nine-member Technical Expert Panel—were to (1) estimate eligibility of AI/ANs for enrollment in Medicaid, SCHIP, and Medicare; (2) develop estimates of the number of AI/ANs in Medicaid, SCHIP, and Medicare; (3) estimate the gap between eligibility and enrollment for AI/ANs, by State and substate areas; and (4) conduct in-depth case studies in 15 States to identify barriers to enrollment and effective strategies for increasing enrollment in these programs.

The project focused on eligibility and enrollment issues in 15 States: AK, AZ, CA, MI, MN, MT, ND, NM, NY, OK, OR, SD, UT, WA, and WI. Eligibility and enrollment estimates were made at the State and county levels using a variety of data sources including the 2000 U.S. Census and data from Indian Health Service (IHS) and CMS. Due to various methodological issues, meaningful estimates of eligibility and enrollment could not be generated. Site visits were conducted in 10 States to examine enrollment barriers so that CMS may develop new education and outreach initiatives to increase enrollment of AI/ANs in Medicaid, SCHIP, and Medicare. The case studies involved interviews

with Tribal leaders, Tribal Health Directors, IHS Area Medical Directors, State Medicaid officials, Urban Health Center Directors, community health representatives, and eligibility and outreach workers, among others. The site visit portion of the project was successful in identifying self-reported barriers to enrollment in Medicaid, SCHIP, and Medicare, as well as in highlighting strategies to further outreach and assistance to help people enroll in these programs.

**Status:** The project has been completed. Four reports have been generated and are available through the CMS Web site: data report, individual site visit report, summary site visit report, and final data-site visit report. ■

### Cancer Prevention and Treatment Demonstration for Ethnic and Racial Minorities Project

**Project No:** 500-00-0031/01
**Project Officer:** Diane Merriman
**Period:** September, 2001 to February, 2004
**Funding:** $835,533
**Principal Investigators:** Sarita Bhalotra and John Capitman
**Award:** Task Order
**Awardee:** Institute for Health Policy
Heller Graduate School
Brandeis University
415 South Street
PO Box 9110
Waltham, MA 02254-9110

**Description:** Congress enacted Section 122 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 legislation, entitled Cancer Prevention and Treatment Demonstration for Ethnic and Racial Minorities, which requires the Secretary of Health and Human Services to evaluate best practices and design, implement, and evaluate demonstration projects for targeted ethnic and racial minorities. The purpose of these demonstration projects is to reduce disparities in cancer prevention and treatment for African American, Latino, Asian American/Pacific Islander, and American Indian/Alaskan Native beneficiary populations living in both urban and rural communities. These demonstration projects will be designed around new and innovative intervention models that improve health, clinical outcomes, satisfaction, quality of life, and appropriate use of Medicare-covered services.

**Status:** The Centers for Medicare & Medicaid Services (CMS) is responsible for conducting these demonstrations, which is being done in two phases. In the first phase, CMS contracted with Brandeis University to conduct a review of the published literature on racial and ethnic disparities related to cancer prevention and treatment and an environmental scan of emerging models and innovative programs. Phase 1 results from the review of evidence and models are currently available on the CMS Web site at www.cms.gov/healthyaging/EvidReports.asp and suggest that a combination of interventions holds the greatest promise for reducing cancer disparities. These interventions include the use of health care facilitation services and information and decisionmaking support systems that focus on cancer prevention, detection, and followup treatment. CMS is currently working on Phase 2, which involves the solicitation of sites to participate in a randomized controlled trial testing promising models and approaches for delivering cancer prevention, screening, and treatment services to the targeted racial and ethnic populations. The results of Phase 2 will be reported to Congress 2 years after the implementation of these demonstrations. ■

### Diabetes Care Across the Life Span for Medicaid Beneficiaries: Gender and Racial Differences

**Project No:** 500-00-0046/01
**Project Officer:** M. Beth Benedict
**Period:** August, 2001 to July, 2004
**Funding:** $214,592
**Principal Investigator:** Anupa Bir
**Award:** Task Order
**Awardee:** Research Triangle Institute
411 Waverly Oaks Road, Suite 330
Waltham, MA 02452-8414

**Description:** This project assists CMS in understanding the magnitude and patterns of utilization of health care services for beneficiaries with diabetes between the ages of 10 and 64 years in four States (Florida, Georgia, Michigan, and New Jersey) from 1996–1998. Chronic diseases contribute significantly to the morbidity and mortality of Americans. Diabetes is a chronic disease of both childhood and adulthood. It is the seventh leading cause of death in this country. However, because diabetes frequently goes undiagnosed, the true burden of this disease is actually not known. The Centers for Disease Control and Prevention (CDC) estimate that the number of persons with undiagnosed diabetes is over 5 million. At the present time, it has been estimated that 10.3 million people have been diagnosed with diabetes in the United States. Although diabetes is more prevalent in the aged, current research has shown that the risk of developing type 2 diabetes for children and young adults is increasing. The rising incidence and prevalence of type 2 diabetes in the younger ages is believed to be related to several factors such as the onset of puberty, overweight and obesity, and lack of physical activity. It has been proposed that future diabetes research be directed toward elucidating the genetic and behavioral aspects of obesity, With more and more young people suffering from this chronic disease, one can expect an increased burden in the future

as these individuals grow older. Identifying potential racial disparities and working toward eliminating these disparities is a key focus for CMS. Although some of the risk factors for diabetes cannot be modified (age, race, gender, etc.), there are risk factors that can be modified, such as level of physical activity, diet, and weight. However, the research has shown that certain cultures or racial/ethnic groups view weight gain and body image in different ways. Therefore, culturally relevant interventions must be developed to change these behaviors. To improve the health care delivered to our beneficiaries, CMS needs to better understand the racial/ethnic composition of its Medicaid beneficiaries. Further, as CMS strives to make inroads in developing cultural competency in the way it administers its programs, having more detailed information on the racial/ethnic composition of its beneficiaries is imperative. The current project will complement the research that we are conducting on diabetes care in the Medicare population. It will provide information on diabetes in children, youth, and/or nonelderly adults who are Medicaid beneficiaries. Thus, findings from this analytic study will assist in setting new directions for future studies and program activities related to diabetes education, prevention, and treatment to improve access and health outcomes for our beneficiaries in the Medicaid program.

**Status:** This project is in the final stages. ■

### Health Disparities: Longitudinal Study of Ischemic Heart Disease Among Aged Medicare Beneficiaries

**Project No:** 500-95-0058/12
**Project Officer:** Linda Greenberg
**Period:** September, 2000 to March, 2003
**Funding:** $282,157
**Principal Investigator:** Jerry Cromwell
**Award:** Task Order
**Awardee:** Research Triangle Institute
411 Waverley Oaks Road, Suite 330
Waltham, MA 02452-8414

**Description:** The purpose of this project is to assess the use of Medicare-covered services among Medicare beneficiaries with ischemic heart disease (IHD) based on sociodemographic characteristics (e.g., race/ethnicity, sex, age, socioeconomic status). This is being done using a longitudinal database consisting of 1997–1999 data that link Medicare enrollment and claims data with small-area geographic data on income (e.g., U.S. Census data or other private data sources). The advantage of a longitudinal database is that it provides data at multiple time points during a person's life. Information is being used to compare the incidence of disease and the outcomes of diagnostic and surgical procedures for IHD across racial/ethnic groups, socioeconomic status, and geographic areas. The unique aspect of this contract is that it examines cardiovascular care among whites, blacks, Hispanics, Asians, and American Indians/Alaska Natives. This project addresses an HHS initiative to eliminate health disparities, which is one of the goals of *Healthy People 2010*.

**Status:** The project is completed and the final report has been submitted. ■

### Health Disparities: Measuring Health Care Use and Access for Racial/Ethnic Populations

**Project No:** 500-00-0024/08
**Project Officers:** Arthur Meltzer and Linda Greenberg
**Period:** September, 2002 to June, 2004
**Funding:** $284,870
**Principal Investigator:** Arthur Bonito
**Award:** Task Order
**Awardee:** Research Triangle Institute
3040 Cornwallis Road
PO Box 12194
Research Triangle Park, NC 27709-2194

**Description:** The purpose of this task order contract is to analyze health care access trends among minority beneficiaries. Detailed data tables and narrative descriptions will be prepared that highlight major trends in health care access and utilization for whites, African Americans, Hispanics, Asians, Pacific Islanders, and American Indians/Alaska Natives. This contract also will focus on examining the accuracy and completeness of race/ethnicity data in the Medicare enrollment database. Results of this contract will provide a better understanding of access to care and utilization of health care services among racial/ethnic populations.

**Status:** The project is ongoing. ■

### Implementation of the READII Survey

**Project No:** 500-00-0032/05
**Project Officer:** Susan Arday
**Period:** September, 2002 to September, 2004
**Funding:** $350,000
**Principal Investigators:** Pascale Wortley, Katherine Ballard-LeFauve, and Pamela Giambo
**Award:** Task Order
**Awardee:** Abt Associates, Inc.
55 Wheeler Street
Cambridge, MA 02138

**Description:** CMS and the Centers for Disease Control and Prevention (CDC) are working with five demonstration sites to improve influenza and pneumococcal vaccination rates in African American and/or Hispanic communities. This contract will implement the READII Survey to a sample of Medicare beneficiaries randomly selected from each of the five demonstration sites. Information will be collected via a telephone survey to evaluate the impact of the Racial and Ethnic Adult Disparities in Immunization Initiative (READII). The demonstration sites use a coalition of public health professionals and medical providers to develop a community-based plan that will identify African American and Hispanic individuals in Medicare who are 65 years of age or over in need of influenza and pneumococcal vaccinations and offer these immunization services to them. The five demonstration sites are Chicago, IL; Bexar County, TX; Milwaukee, WI; Monroe County, NY; and selected counties in rural Mississippi. Specific activities include, but are not limited to (1) drawing a random sample of cases from the Medicare Enrollment Database, (2) obtaining telephone numbers for those cases using telephone-address match vendors and Directory Assistance, (3) sending out advance (prenotification) letters with postage-paid return postcards, (4) conducting telephone interviews over an 8–12 week period, (5) conducting interviews in English and Spanish, (6) obtaining at least 400 completed interviews per subgroup (white and African American and/or Hispanic) at each demonstration site, and (7) targeting a response rate of 60 percent or higher (after excluding those for whom a telephone number could not be obtained).

**Status:** Demonstration project activities began in September 2002 and will continue for a 2-year period. Evaluation measures include outcome (proportion immunized) and process (change in knowledge). The intra-agency agreement (IAA) initially covered a 12-month period from 9/12/2002 through 9/14/2003, during which time the first round of the READII Survey was conducted, and data were collected from February through May 2003. At the discretion of both CMS and CDC, a second round of READII Survey activities is taking place over the 12-month period starting on 9/15/2003 and running until 9/29/2004. The second round of the READII Survey will be conducted, and data will be collected from February through May 2004. ■

## Racial Disparities in Health Services Among Medicaid Pregnant Women, (Multistate) Analysis

**Project No:** 500-96-0018/02
**Project Officer:** M. Beth Benedict
**Period:** September, 2000 to January, 2005
**Funding:** $430,779
**Principal Investigator:** Norma Gavin
**Award:** Task Order
**Awardee:** Research Triangle Institute
3040 Cornwallis Road
PO Box 12194
Research Triangle Park, NC
27709-2194

**Description:** The study examines pregnancy and delivery-related health care service use among Medicaid pregnant women in four racially diverse States during the mid 1990s to determine how successful the States' efforts were in eliminating racial barriers to care within Medicaid. The first paper investigates racial differences in demographic, Medicaid enrollment, and medical risk factors associated with disparities in health service use and whether race/ethnicity had an independent effect on use after controlling for these factors. Another aspect of the study was to examine differences across race/ethnicity in geographic dimensions of provider supply and the effects of these differences on prenatal care utilization. Also included was an investigation of racial disparities in two maternal outcomes—cesarean section delivery and hospital readmissions in the first 3 months following delivery. Most race/ethnicity research reports disparities among black and white pregnant women. Few studies provide information on both prenatal and postnatal care, comorbidities, and complications and also show results for Hispanic and Asian American women. This study looked at all of these areas. The study populations were women who had a live birth in 1995 in Florida, Georgia, and New Jersey; and in 1997 in Texas.

**Status:** The project results have been delivered to CMS. Manuscripts have been submitted to peer review journals. ■

### Daycare, Respite Care, Emergency Services, and Social Services to HIV-Infected Children

**Project No:** 18-P-91854/04-01
**Project Officer:** Jean Close
**Period:** September, 2003 to September, 2004
**Funding:** $99,350
**Principal Investigator:** Elizabeth Dupont
**Award:** Grant
**Awardee:** Hope House Daycare
23 South Idlewild
Memphis, TN 38174-1437

**Description:** Hope House Day Care offers day care services for children age 6 weeks to 5 years of age with HIV/AIDS. The objectives of the Hope House Project include (1) providing therapeutic day care and drop-in respite care; (2) providing material support, transportation, and emotional support to children and their families; (3) coordinating services for families; and (4) preparing preschool children for entry into kindergarten.

**Status:** This is a new project. ■

### START Program: Success Through Anti-Retroviral Therapy —III

**Project No:** 15-P-91118/09
**Project Officer:** Jean Close
**Period:** March, 2000 to March, 2003
**Funding:** $3,700,000
**Principal Investigator:** Michael Weinstein
**Award:** Grant
**Awardee:** AIDS Healthcare Foundation
6255 West Sunset Boulevard
16th Floor
Los Angeles, CA 90028

**Description:** The START Program is a 4- to 6-week residential program designed to increase adherence to human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) medication regimens of individuals at high risk for nonadherence or with a history of nonadherence.

The objectives of the START program follow:

- To provide a supervised residential environment for initiation and continuation of the latest HIV medication therapies
- To implement a structured educational program to meet the needs of the patient receiving complicated HIV treatment regimens
- To provide psychosocial support to the patient and his or her family
- To provide direct observation therapy during residency until the patient demonstrates the knowledge and ability to self-administer doses appropriately

The purpose of the project was to demonstrate how compliance with the complicated medication regimen for people living with HIV and AIDS, who are at high risk of noncompliance, can be increased by a short-term residential treatment program.

**Status:** The project has been continued. ■